ACE Inhibitors, Angiotensin II Receptor Antagonists, Beta-Blockers

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class? Acceptable reasons include:
- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Document clinically compelling information

The requested medication may be approved if both of the following are true:
- If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** medication **within the same class** not requiring prior approval
- The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated

ADDITIONAL INFORMATION TO AID IN FINAL DECISION

If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then may approve the requested medication. Document details. This medication should be reviewed for need at each request for reauthorization.

See next page for specific drug lists.

ACE Inhibitors, Angiotensin II Receptor Antagonists, Beta-Blockers *(page 2)*

ACE INHIBITORS and HCTZ COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
CAPTOPRIL (compares to Capoten®) CAPTOPRIL/ HCTZ (compares to Capozide®) ENALAPRIL (compares to Vasotec®) ENALAPRIL/ HCTZ (compares to Vaseretic®) LISINOPRIL (compares to Zestril®, Prinivil®) LISINOPRIL/HCTZ (compares to Zestoretic®, Prinzide®)	ACCUPRIL® ACCURETIC® ACEON® ALTACE® BENAZEPRIL *CAPOTEN®* *CAPOZIDE®* FOSINOPRIL LOTENSIN® LOTENSIN HCT® MAVIK® MOEXIPRIL MONOPRIL® MONOPRIL HCT® *PRINIVIL®* *PRINIZIDE®* UNIRETIC® UNIVASC® *VASERETIC®* *VASOTEC®* *ZESTORETIC®* *ZESTRIL®*

ACE INHIBITOR PLUS CALCIUM CHANNEL BLOCKER COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LOTREL® (Norvasc® and Lotensin®)	LEXXEL® (Plendil® and Enalapril) TARKA® (Verapamil and Trandolapril) TECZEM® (Diltiazem and Enalapril)

ANGIOTENSION II RECEPTOR ANTAGONISTS and HCTZ COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BENICAR® BENICAR HCT® DIOVAN® DIOVAN HCT® MICARDIS® MICARDIS HCT®	ATACAND® ATACAND HCT® AVALIDE® AVAPRO® COZAAR® HYZAAR® TEVETEN® TEVETEN HCT®

ACE Inhibitors, Angiotensin II Receptor Antagonists, Beta-Blockers *(page 3)*

BETA-BLOCKERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
ACEBUTOLOL (compares to Sectral®) ATENOLOL (compares to Tenormin®) ATENOLOL /CHLORTHALIDONE (compares to Tenoretic®) BETAXOLOL (compares to Kerlone®) BISOPROLOL FUMARATE (compares to Zebeta®) BISOPROLOL/HCTZ (compares to Ziac®) COREG® LABETALOL (compares to Trandate®) METOPROLOL TARTRATE (compares to Lopressor®) NADOLOL (compares to Corgard®) PINDOLOL (compares to Visken®) PROPRANOLOL (compares to Inderal®) PROPRANOLOL/HCTZ (compares to Inderide®) SORINE (compares to Betapace®) SORINE AF (compares to Betapace AF®) SOTALOL (compares to Betapace®) SOTALOL AF (compares to Betapace AF®) TIMOLOL (compares to Blocadren®)	*BETAPACE®* *BETAPACE AF®* *BLOCADREN®* CARTROL® *CORGARD®* CORZIDE® (Nadolol/Bendroflumethiazide) *INDERAL®* INDERAL LA *INDERIDE®* INNOPRAN XL® *KERLONE®* LEVATOL® *LOPRESSOR®* LOPRESSOR HCT® *SECTRAL®* *TENORETIC®* *TENORMIN®* TIMOLIDE® TOPROL XL® *TRANDATE®* *ZEBETA®* *ZIAC®*

TOPROL XL®: Authorize if any of the following are true
• Toprol XL® 25mg po qd will be authorized as it would not be feasible to promote metoprolol 12.5mg po BID. Toprol XL® 25mg will be authorized with a quantity limit of 45 tablets per 30 days.
Doses >37.5 mg Toprol XL® po qd will be offered a change to metoprolol in a total daily dose divided by two and dosed BID
• If patient compliance is questioned or compromised by change, then the Toprol XL® will be authorized

Antibiotics: Cephalosporins, Macrolides, Quinolones

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
   Acceptable reasons include:
   Allergy to product formulation (i.e. dyes, fillers). If allergy to drug class, should question medication request.
   Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   History of unacceptable/toxic side effects to medications not requiring prior approval
   Document clinically compelling information

2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication. Document details.
   - Note diagnosis and any culture and sensitivity reports

3. If there has been a therapeutic failure to no less than a **three-day** trial of **one** medication within the same not requiring prior approval, then may approve the requested medication. Document details.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

If the patient requires a prior authorized medication based on a specific medical need that is not covered by the FDA indications of the preferred medications, then allow the non-preferred medication. This information should be reviewed at each request for reauthorization.

CEPHALOSPORINS - SECOND GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
CEFACLOR CEFACLOR Suspension CEFACLOR ER CEFTIN 125 mg (until generic available) CEFTIN® Suspension CEFUROXIME (compares to Ceftin®) CEFZIL® CEFZIL® Suspension LORABID® LORABID® Suspension	*CECLOR®** *CECLOR CD®** *CEFTIN®**

CEPHALOSPORINS - THIRD GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CEDAX® CEDAX® Suspension OMNICEF® OMNICEF® Suspension SPECTRACEF®	SUPRAX® Suspension VANTIN® VANTIN® Suspension

Antibiotics – Cephalosporins, Macrolides, Quinolones *(page 2)*

MACROLIDES

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
BIAXIN® BIAXIN® Suspension BIAXIN XL® ERYTHROCIN STEARATE ERYTHROMYCIN BASE ERYTHROMYCIN ETHYLSUCCINATE ERYTHROMYCIN ESTOLATE Suspension ERYTHROMYCIN STEARATE ERYTHROMYCIN W/SULFISOXAZOLE PEDIAZOLE® ZITHROMAX® ZITHROMAX® Suspension	DYNABAC® *E.E.S.* ® *ERYC*® *ERYPED*® *PCE*®

QUINOLONES - SECOND GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CIPRO® CIPRO® Suspension CIPRO XR®	CIPROFLOXACIN (generic for Cipro®) FLOXIN® MAXAQUIN® NOROXIN® OFLOXACIN

QUINOLONES - THIRD GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AVELOX® AVELOX ABC PACK®	LEVAQUIN® TEQUIN® ZAGAM®

Antifungals (Oral) for Onychomycosis

LENGTH OF AUTHORIZATIONS: For the duration of the prescription (up to 6 months)

Is there any reason the patient cannot be changed to a medication not requiring prior approval?
Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

If the patient has a serious illness that causes them to be immunocompromised (i.e. AIDS, cancer, etc.) then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring prior approval, then may approve the requested medication.

2. If the request is for a diagnosis other than fungal infection, please refer to a clinical pharmacist.

Sporanox

If Sporanox is requested for any other FDA approved indication (other than onychomycosis), then approve for 6 months or the duration of the prescription.

Indications: Aspergillosis, Candidiasis (oral or esophageal), Histoplasmosis, Blastomycosis, empiric treatment of febrile neutropenia

Transfer requests for any other diagnosis to a clinical pharmacist.

ORAL ANTIFUNGALS USED FOR ONYCHOMYCOSIS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LAMISIL®	SPORANOX®

Antihistamines: Second Generation

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

   Document clinically compelling information

2. If there has been a therapeutic failure after a course of treatment (e.g., one month for allergic rhinitis) with a preferred product (loratadine), then may approve the requested medication. Document details

ANTIHISTAMINES: SECOND GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
ALAVERT® (compares to Claritin® Redi-tab and Claritin® tablets but is available OTC) CLARITIN D® (OTC only) LORATADINE syrup (compares to Claritin®) LORATADINE tablets (compares to Claritin®)	ALLEGRA® ALLEGRA D® CLARINEX® *CLARITIN®* CLARITIN D 12 HOUR® (Rx) CLARITIN D 24 HOUR® (Rx) *CLARITIN REDI-TAB®* *CLARITIN SYRUP®* (no PA req. for children < 6 years) ZYRTEC® ZYRTEC D® ZYRTEC SYRUP® (no PA req. for children < 2 years)

Antimigraine Medications: Serotonin Receptor Agonists "Triptans"

LENGTH OF AUTHORIZATIONS: 6 months

1. Is there any reason the patient cannot be switched to a non-prior approved medication? Acceptable reasons include:
   - Allergy to **one** of the non-prior approved products
   - Contraindication to all non-prior approved product(s)
   - History of unacceptable side effects to **one** of the non-prior approved product(s)

   Document clinically compelling information

2. Has the patient had therapeutic trial of **one** non-prior authorized drug that failed? If so, document and allow the prior authorized medication.

CLINICAL CONSIDERATIONS:

Prior Authorization will not be given for prophylactic therapy of migraine headache unless the patient has exhausted or has contraindications to all other "controller" migraine medications (i.e., beta-blockers, calcium channel blockers, etc) and the physician and patient are aware of the adverse risk potential.

NO PA REQUIRED "PREFERRED"	PA REQUIRED
IMITREX® (kit, nasal, tablets, vial) MAXALT® MAXALT-MLT®	AMERGE® AXERT® FROVA® RELPAX® ZOMIG® ZOMIG-ZMT®

Beta-Adrenergic Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation?
   Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

   Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **two-week** trial of at least **one** medication not requiring prior approval **within the same class and formulation**. (ie nebulizers for nebulizers)

ADDITIONAL INFORMATION

Patients experience cardiac and central nervous system side effects (i.e. tachycardia, agitation) more often.

See next page for specific drug lists.

Beta-Adrenergic Agents *(page 2)*

BETA-ADRENERGIC AGENTS
Short Acting and Combination Meter Dose Inhalers or Inhalation Devices

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
ALBUTEROL (compares to Proventil®, Ventolin®) ALUPENT® MDI (Metaproterenol) COMBIVENT® MDI (Ipratropium/Albuterol) MAXAIR AUTONHALER® (Pirbuterol) PROVENTIL® HFA (Albuterol) VENTOLIN® HFA (Albuterol)	*PROVENTIL®* *VENTOLIN®*

BETA-ADRENERGIC AGENTS: LONG ACTING Meter Dose Inhalers

NO PA REQUIRED "PREFERRED"	PA REQUIRED
FORADIL® (Formoterol) SEREVENT DISKUS® (Salmeterol)	

BETA-ADRENERGIC AGENTS: SHORT-ACTING and COMBINATION Nebulizers

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
ACCUNEB® (Albuterol – pediatric dosing of premixed nebs) ALBUTEROL (compares to Proventil®, Ventolin®) DUONEB® (Ipratropium/Albuterol) nebs METAPROTERNOL (compares to Alupent® for nebulization) XOPENEX® (Levalbuterol nebulization)	PROVENTIL®

Calcium Channel Blockers:
Dihydropyridine Calcium Channel Blockers and Non-dihydropyridine Calcium Channel Blockers

CLINICAL NOTES

There are two main classes of Calcium Channel Blockers (each with different actions on the peripheral vasculature and cardiac tissue) :

1. Dihydropyridine Calcium Channel Blockers (DHPCCB)
2. Non-Dihydropyridine Calcium Channel Blockers (NDHPCCB)

Vascor is in its own third class of Calcium Channel Blockers and not included under PA requirements on the VA PDL at this time.

The requested medication may be approved if both of the following are true:

1. If there has been a therapeutic failure to no less than a **one-month** trial of at least **one** medication **within the same class** not requiring prior approval

2. The requested medications corresponding generic (if a generic is available and covered by the state) has been attempted and failed or is contraindicated

See next page for specific drug lists.

Calcium Channel Blockers:
Dihydropyridine Calcium Channel Blockers and Non-dihydropyridine Calcium Channel Blockers (cont.)

Dihydropyridine Calcium Channel Blockers (DHPCCB)

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
AFEDITAB CR®	*ADALAT CC®*
DYNACIRC®	*CARDENE®*
DYNACIRC CR®	CARDENE SR®
NICARDIPINE	*PROCARDIA®*
NIFEDIAC CC®	*PROCARDIA XL®*
NIFEDICAL XL®	
NIFEDIPINE ER	
NIFEDIPINE IMMEDIATE RELEASE	
NIFEDIPINE SA	
NORVASC®	
PLENDIL®	
SULAR®	

NON Dihydropyridine Calcium Channel Blockers (NDHPCCB)

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
CARTIA XT®	*CALAN®*
DILTIA XT®	*CALAN SR®*
DILTIAZEM (compares to Cardizem®)	*CARDIZEM®*
DILTIAZEM extended/sustained release	*CARDIZEM CD®*
TAZTIA XT®	*CARDIZEM LA®*
VERAPAMIL (compares to Calan®)	*CARDIZEM SR®*
VERAPAMIL extended/sustained release	COVERA HS®
	DILACOR XR®
	ISOPTIN SR®
	TIAZAC®
	VERELAN®
	VERELAN PM®

Central Nervous System Stimulants/ADHD Medications

LENGTH OF AUTHORIZATION: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

   Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** medication not requiring prior approval, then may approve the requested medication. Document details.

3. The patient must have failed the generic product (if covered by the State) before the brand is authorized.

4. If the patient requires a prior authorized medication based on a specific medical need that is not covered by the FDA indications of the preferred medications, then allow the non-preferred medication. This should be reviewed for need at each request for reauthorization.

Central Nervous System Stimulants/ADHD Medications *(page 2)*

DEXTROAMPHETAMINE and DEXTROAMPHETAMINE and AMPHETAMINE MIXTURES

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
ADDERALL XR® AMPHETAMINE SALT COMBO DEXTROAMPHETAMINE DEXTROAMPHETAMINE SR DEXTROSTAT®	*ADDERALL®* DESOXYN® *DEXEDRINE®* *DEXEDRINE SPANSULES®*

METHYLPHENIDATE PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
CONCERTA® FOCALIN® METADATE CD® METADATE ER METHYLIN® METHYLIN ER® METHYLPHENIDATE METHYLPHENIDATE SR RITALIN LA®	*RITALIN®* *RITALIN SR®*

MISCELLANEOUS

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
PEMOLINE STRATTERA®	*CYLERT®* PROVIGIL®

COX-2 Inhibitors

LENGTH OF AUTHORIZATIONS: 1 year

If the patient is **60 years of age or older** no PA is required for Vioxx®.

The preferred product Vioxx may be approved for patients less than 60 years of age* if one of the following is true:

- If there has been a therapeutic trial and failure on a minimum of two (2) different non-COX2 NSAIDs
- Concurrent use of anticoagulants (warfarin or heparin)
- Chronic use of oral corticosteroids
- Concurrent use of methotrexate
- History of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc.)
- If there is a specific indication for medication requiring prior approval, for which medications not requiring prior approval are not indicated, then document details and refer caller to a clinical pharmacist
- Patients with a diagnosis of familial adenomatous polyposis (FAP) presenting with a prescription for celecoxib (Celebrex®) may be approved without any risk factors or trials on NSAIDs.

Celebrex® and Bextra® require a therapeutic failure of the preferred product (Vioxx®).
The above clinical criteria must also be met and one of the following must be true:

- There has been a therapeutic failure to no less than a **one-month** trial of the preferred product or there is a clinical contraindication to a trial of the preferred product (Vioxx®).
- There is a specific indication for medication requiring prior approval, for which medications not requiring prior approval are not indicated, then document details and refer to pharmacist.

CRITICAL INFORMATION TO CONSIDER

1. If the patient is allergic to one NSAID or aspirin, the patient may be allergic to other NSAIDs.
2. If allergic to sulfonamides, a patient should not receive Celebrex® or Bextra®.

ANALGESICS: COX-II's

≥ 60 years of age NO PA REQUIRED	PA REQUIRED
VIOXX	BEXTRA® CELEBREX® VIOXX® **(if under 60 years of age*)**

*** Those patients who are under 60 and have had Cox-2 therapy between January 1st and June 30th of 2004 will be able to continue without disruption of service until their current prior authorization expires, or until June 30, 2005 which ever comes first.**

Gastrointestinals: H2RAs

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval?
Acceptable reasons include:
Allergy to medications not requiring prior approval
Contraindication to or drug-to-drug interaction with medications not requiring prior approval
History of unacceptable/toxic side effects to medications not requiring prior approval
Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.
Document clinically compelling information

If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** similar medication not requiring prior approval, then may approve the requested medication.
Document details

If a medication requiring prior approval was initiated in the hospital for the treatment of a condition such as a GI bleed, then may approve the requested medication.

GASTROINTESTINALS: H2RAS

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
RANITIDINE (Generic for Zantac®)	AXID® CIMETIDINE (generic for Tagamet®) FAMOTIDINE (generic for Pepcid®) NIZATIDINE (generic for Axid®) PEPCID® PEPCID SUSPENSION® TAGAMET® *ZANTAC®* ZANTAC EFFERVESCENT® ZANTAC SYRUP® (No PA required if < 12 yrs)

Gastrointestinals: Proton Pump Inhibitors

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   Allergy to medications not requiring prior approval
   Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   History of unacceptable/toxic side effects to medications not requiring prior approval
   Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.
   Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **one-month trial** with Protonix, then may approve the requested medication.
   Document details

3. If a medication requiring prior approval was initiated in the hospital for the treatment of a condition such as a GI bleed, then may approve the requested medication.

GASTROINTESTINALS: PPIS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
PROTONIX® PRILOSEC® OTC	ACIPHEX® NEXIUM® OMEPRAZOLE (No PA required if < 12 yrs) PREVACID® (No PA required if < 12 yrs) PREVACID® Susp (No PA required if < 12 yrs) PREVACID SoluTab® PRILOSEC® (Rx)

SPECIAL CONSIDERATION:

Protonix® is a delayed release tablet and cannot be crushed or opened. For tubed patients or patients with swallowing difficulties omeprazole, Prevacid®, Prevacid Solutab®, Prilosec®, Nexium or Prevacid® granules (if oral administration) can be used. These Proton Pump Inhibitors may be opened and the intact granules may be mixed in apple sauce or orange juice and administered. Alternatively, the capsules may be opened and the granules may be dissolved in a small amount of sodium bicarbonate to form a compounded suspension for administration. The omeprazole will be the preferred agent for these circumstances and may be approved. If there has been a therapeutic failure on omeprazole or there is a clinical contraindication to omeprazole then another non-preferred agent may be approved.
Aciphex® is an extended release tablet and should not be opened or crushed .

Glaucoma Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
   Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
     Document clinically compelling information

2. The requested medication may be approved if both of the following are true:
   If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** medication **within the same class** not requiring prior approval

3. The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated

Glaucoma Agents *(page 2)*

ALPHA 2 ADRENERGIC AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
ALPHAGAN P® BRIMONIDINE TARTRATE IOPIDINE®	*ALPHAGAN®*

BETA BLOCKERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
BETAXOLOL HCL BETIMOL® BETOPTIC S® CARTEOLOL HCL LEVOBUNOLOL HCL METIPRANOLOL TIMOLOL MALEATE TIMOLOL MALEATE gel-forming	*BETAGAN®* *OCUPRESS®* OPTIPRANOLOL® *TIMOPTIC®* *TIMOPTIC XE®*

CARBONIC ANHYDRASE INHIBITOR (CAI)

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AZOPT® COSOPT® TRUSOPT®	

PROSTAGLANDIN ANALOGS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LUMIGAN® TRAVATAN® XALATAN®	RESCULA®

Glucocorticoids:
Inhaled and Nasal Steroids

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
   Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
   - Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

   Document clinically compelling information

2. If there have been therapeutic failures to no less than **one-month** trials of at least **two** medications not requiring prior approval, then may approve the requested medication.
   Document details

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. If a medication requiring prior approval was initiated in the hospital, then may approve the requested medication.
   Document details

2. If the patient is a child <13 years old or a patient with a significant disability, and unable to use an inhaler which does not require prior approval, or is non-compliant on an inhaler not requiring prior approval because of taste, dry mouth, infection; then may approve the requested medication.
   Document details

See next page for specific drug lists.

Glucocorticoids: Inhaled Steroids

GLUCOCORTICOIDS: INHALED

GLUCOCORTICOIDS: Meter Dose Inhalers Only

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AEROBID® AEROBID M® AZMACORT® FLOVENT® QVAR®	FLOVENT ROTADISK® PULMICORT TURBUHALER®

GLUCOCORTICOIDS and LONG-ACTING BETA$_2$ ADRENERGIC AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ADVAIR DISKUS® (Salmeterol/Fluticasone)	

GLUCOCORTICOIDS: Nebulized

NO PA REQUIRED "PREFERRED"	PA REQUIRED
PULMICORT® RESPULES NEBULIZER SOLUTION	

Glucocorticoids: Intranasal Steroids

GLUCOCORTICOIDS: INTRANASAL STEROIDS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
FLONASE® FLUNISOLIDE NASALIDE® NASAREL®	BECONASE AQ® NASACORT® NASACORT AQ® NASONEX® (no PA required if < 4 years) RHINOCORT AQUA® TRI-NASAL®

Leukotriene Receptor Antagonists

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
   Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

   Document clinically compelling information

2. If there has been a therapeutic failure to the agent not requiring prior approval, then may approve the requested medication.
   Document details

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACCOLATE® SINGULAIR®	

Lipotropics

LENGTH OF AUTHORIZATIONS: 1 year

Trial period	1 month (30 days) for HMG COA Reductase Inhibitors,
Number of non-PA agents (generic)	1 medication – The assumption is that the medication must be in the same class of the medication requested
Length of Authorization	1 year

General Guidelines:
Currently there are three classes of medications in the Lipotropics represented. Each class has a different mechanism of action and acts on different components of total cholesterol

Fibric acid derivatives *(not included in VA PDL at this time)*
HMG COA reductase Inhibitors
Nicotinic acid derivatives *(not included in VA PDL at this time)*
Bile Acid Resins *(not included in VA PDL at this time)*

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
   Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
   - Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

   Document clinically compelling information

2. If there have been therapeutic failures to no less than **one-month** trials of at least **one** medication not requiring prior approval, then may approve the requested medication.
   Document details

HMG-COA Reductase Inhibitors "Statins"

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
ADVICOR® ALTOCOR® LESCOL® LESCOL XL® LOVASTATIN (compares to Mevacor®) PRAVACHOL® ZOCOR®	CADUET® (Norvasc® and Lipitor®) CRESTOR® LIPITOR® *MEVACOR®*

NSAIDs (Non-Steroidal Anti-inflammatory Drugs)

LENGTH OF AUTHORIZATIONS: 1 YEAR

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
   Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

   Document clinically compelling information

2. The requested medication may be approved if **both** of the following are true:
   - If there has been a therapeutic failure to no less than a **one-month** trial of at least **two** medication(s) within the same class not requiring prior approval
   - The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

3. If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then document details and refer to a clinical pharmacist.

ADDITIONAL INFORMATION TO CONSIDER

If the patient is allergic to one NSAID or aspirin, the patient may be allergic to other NSAIDs.

NSAIDs (Non-Steroidal Anti-inflammatory Drugs)

(page 2)

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
DICLOFENAC POTASSIUM (Generic for Cataflam®) DICLOFENAC SODIUM (Generic for Voltaren®) DIFLUNISAL (Generic for Dolobid®) ETODOLAC (Generic for Lodine® and Lodine XL®) FENOPROFEN (Generic for Nalfon®) FLURBIPROFEN (Generic for Ansaid®) IBUPROFEN (Generic for Motrin®) INDOMETHACIN (Generic for Indocin®) INDOMETHACIN SR (Generic for Indocin SR®) KETOPROFEN (Generic for Orudis®) KETOPROFEN ER (Generic for Oruvail®) KETOROLAC (Generic for Toradol®) MECLOFENAMATE SODIUM (Generic for Meclomen®) MOBIC® NABUMETONE (Generic for Relafen®) NAPROXEN (Generic for Naprosyn®) NAPROXEN SODIUM (Generic for Anaprox®) OXAPROZIN (Generic for Daypro®) PIROXICAM (Generic for Feldene®) SULINDAC (Generic for Clinoril®) TOLMETIN SODIUM (Generic for Tolectin® and Tolectin DS®)	*ANAPROX®* *ANAPROX DS®* *ANSIAD®* ARTHROTEC 50® ARTHROTEC 75® *CATAFLAM®* *CLINORIL®* *DAYPRO®* *DOLOBID®* *FELDENE®* *INDOCIN®* *LODINE®* *LODINE XL®* *MOTRIN®* *NALFON®* *NAPRELAN®* PREVACID NAPRAPAC® *(must also meet PPI criteria – see page 17)* *NAPROSYN®* *ORUDIS®* *ORUVAIL®* PONSTEL® *RELAFEN®* *TOLECTIN DS®* *TORADOL®* *VOLTAREN®* *VOLTAREN-XR®*

Oral Hypoglycemics

LENGTH OF AUTHORIZATIONS: 1 YEAR

1. Is there any reason the patient cannot be switched to a non-prior approved medication? Acceptable reasons include:
   - Allergy to the non-prior approved products in this class
   - Contraindication or drug to drug interaction with all non-prior approved products
   - History of unacceptable side effects

   Document clinically compelling information

2. Has the patient tried and failed a therapeutic trial of thirty days with **one** of the non-preferred drugs **within the same class**? If so, document and approve the prior authorized drugs.

ALPHA-GLUCOSIDASE INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
GLYSET® (Miglitol) PRECOSE® (Acarbose)	

BIGUANIDES

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
METFORMIN (compares to Glucophage®) METFORMIN ER (compares to Glucophage XR®) GLUCOPHAGE XR 750MG (until generic available)	*GLUCOPHAGE®* *GLUCOPHAGE XR®*

BIGUANIDES COMBINATION PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
GLUCOVANCE® (Metformin/Glyburide) METAGLIP® (Metformin/Glipizide) AVANDAMET® (Metformin/Avandia)	

MEGLITINIDES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
STARLIX®	PRANDIN®

THIAZOLIDINEDIONES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACTOS® AVANDIA®	

SULFONYLUREAS SECOND GENERATION

NO PA REQUIRED "PREFERRED"	*PA REQUIRED* *(medications in italics have a preferred generic available)*
GLIPIZIDE (compares to Glucotrol®) GLIPIZIDE ER (compares to Glucotrol XL®) GLYBURIDE (compares to Diabeta®) GLYBURIDE MICRONIZED (compares to Glynase®)	AMARYL® *DIABETA®* *GLUCOTROL®* *GLUCOTROL XL®* *GLYNASE®* *MICRONASE®*

Osteoporosis Agents - Bisphosphonates

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
   Acceptable reasons include:
   - Allergy to medication not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medication not requiring prior approval
   - History of unacceptable/toxic side effects to medication not requiring prior approval

   Document clinically compelling information

2. Has the patient tried and failed a therapeutic trial with a non-preferred drug **within the same class**? If so, document and approve the prior authorized drug.

Bisphosphonates

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACTONEL®	FOSAMAX®

Sedative/Hypnotics (Non-Barbiturate)

LENGTH OF AUTHORIZATIONS: Length of the prescription (up to 3 months)

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
   - Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **one-month** trial of at least **one** medication not requiring prior approval, then may approve the requested medication. Document details

3. If the request is for Ambien® for a **pregnant** patient, approve the Ambien® for the duration of the prescription or the duration of the pregnancy (whichever is shorter).

4. For **patients age 65 and older**, Ambien may be approved after a trial of trazodone (duration = at least one month). It is not necessary for patients ≥ 65 to try a benzodiazepine if they have had a trial of trazodone.

SEDATIVE / HYPNOTICS (NON-BARBITURATE)

NO PA REQUIRED "PREFERRED"	PA REQUIRED *(medications in italics have a preferred generic available)*
ESTAZOLAM (compares to Prosom®) FLURAZEPAM (compares to Dalmane®) RESTORIL® 7.5 mg (until generic available) TEMAZEPAM (compares to Restoril®) TRIAZOLAM (compares to Halcion®)	AMBIEN® *DALMANE®* DORAL® *HALCION®* *PROSOM®* *RESTORIL®* SOMNOTE® SONATA®